**WELCOME QUESTIONAIRE**

How did you learn about our services?



**CHILD/YOUTH INFORMATION:**

Child/Youth’s Birth Name: 

Child/Youth’s Chosen Name: 

Child/Youth Pronouns:  He/Him  She/Her  They/Them

Child/Youth Date of Birth: 

Address (Street & Number): 

Address (City, State, Zip): 

Safe to send mail to the above address?  Yes  No

Child/Youth Telephone Contact: 

Can we leave a message at this number?  Yes  No

Email: 

Emergency Contact Name, Relation, and Number:



Insurance Provider: 

Insurance ID Number: 

What is the main reason you are seeking services?

|  |  |
| --- | --- |
| Anger/Aggression  Anxiety  Depression/Hopelessness  Eating/Food Issues  Elevated Mood  Fear  Grief/Bereavement  Guilt  Hyperactivity  Loneliness  Other: | Loss of Interests  Obsessive Thoughts  Relationship Issues with Others:  Self-Doubt/Self-Esteem  Self-Harm  Sleep Problems  Strange Thoughts/Disturbed Reality (hallucinations, delusions, disorganized thinking)  Substance or Alcohol Abuse:  Suicidal Thoughts and Feelings  Traumatic Stress |

Where do these problems impact you?:  Home  School  Work  With friends  All the time  Other: 

How often do these concerns occur?  Daily Weekly  Monthly  Other: 

How long have they been occurring? 

**PRIMARY CAREGIVER/GUARDIAN INFORMATION:**

Primary Caregiver/Guardian Name: 

Relation to Child: 

Phone Number: 

Can we leave a message at this number?  Yes  No

Email: 

Availability for Services (Days and Times):

